Systems Linkage Workgroup Meeting: May 10, 2012
Notes

- It would be helpful to identify which linkages exist and which don't. Of the ones that exist, which are effective and which could we do without? Of the ones that don't, what should we add? Commenters seeking feedback from what the Department is looking for.
- Financial incentives to integration for providers, both on the receiving side and the referring side (IT incentives could be effective as well)
    - What is currently paid for? What isn't and should be? A financing model should be based on performance and outcomes instead of paying for each service, and then we wouldn't have to think about what specific services Medicaid should reimburse.
- Some people, and a high rate of this population, aren't capable of self-directing after initial entry. They need informed assistance getting to other doctors/appointments.
- What percentage of clients actually want integration?
- Integration can be driven by PCPs for the general population; integration should be driven by behavioral health providers for SMI population.
- Clustering the general population from the SMI population may not be a good idea. Illnesses don't always stay high-severity, and this "flies in the face" of the recovery model.
- Coordination of care between Medicaid and private insurance is critical, especially with the high churn rate we're expecting in this population.
- Coordination between systems, like the criminal justice system for adults and children, is critical
- Need to align the language and philosophy of SUD and MH providers. For instance, "recovery" may mean different things to different providers. Treatment/recovery plans need to be collaborated upon to ensure best outcomes and reduce duplicating efforts.
- One administration doesn't guarantee integration; integration doesn't sit in the financing model
- We could connect SUD and MH before integrating into somatic care
- This population is expanding to include people currently not in any system at the same time as integration; what do they look like? How would an MCO/BHO set rates? Is one model more better suited for an unknown population?